Comments on FCC Proposed Rulemaking
Rural Health Care Support Mechanism
WC Docket No. 02-60
February 23, 2004

Submitted by Rural Healthcare Center
California Healthcare Association
Sacramento, CA

Table of Contents

Comments on FCC Proposed Rulemaking
Rural Health Care Support Mechanism
WC Docket No. 02-60

Submitted by Rural Healthcare Center
California Healthcare Association
Sacramento, CA

BACKGROUND

Rural Healthcare Center at the California Healthcare Association oversees California's 73 small and rural hospitals. These hospitals serve 2.6 million residents located in communities with less that 5,000 that are geographically dispersed over 75 percent of the state's land mass. These hospitals range in the number of licensed beds from two to 76 with an average of 36 beds. Most skilled nursing, home health, clinical and primary care services are available because of the hospital's presence in these rural areas and as a result. The majority of these hospitals lose money on their operations

(75 percent) and have an average operating margin of -3.9 percent.

The Universal Service program has been essential for the growth and development of telemedicine services in California. Program improvements and streamlining, approved by the FCC in 2003 and scheduled for implementation this year, will help the program benefit even more rural health providers. The purpose of our comments in this document is to express significant concern about how the FCC will define "rural" for future program years and to express our support for a simplified annual recertification process.

A. SUMMARY OF NSRHN RECOMMENDATIONS

a. Definition of rural. The Rural Healthcare Center recommends that the FCC make the following modifications to the definition of "rural area" for the rural health care universal service support mechanism:

1) Instead of using a national definition of rural (such as RUCA), the FCC should allow for state-definitions of rural that have been recognized by another federal

agency. This ensures that the Universal Service program will be responsive to the unique characteristics of the many rural communities within our 50 states, while maintaining a minimum amount of federal oversight.

2) If a state does not have a definition of rural recognized by a federal agency, allow organizations to define themselves as rural using the definitions of any federal program, such as the Office of Rural Health Policy or the US Department of Agriculture. This flexibility will overcome the limitations of a "one-size fits all" approach to rural definitions and allow the maximum number of rural communities to benefit from this program.
3) If the FCC chooses to develop a single, national definition for its program, then it should develop a process that enables organizations to appeal their exclusion as being rural under the FCC definition by demonstrating they are rural under another federal definition or a state process that has been recognized by a federal agency. Instituting this type of an appeal process will provide maximum opportunity for rural communities to demonstrate that they are rural. The USAC staff should manage this appeal process so it can respond in a timely manner to organizations seeking an appeal.
4) Regardless of which definitions the FCC select, organizations that are currently eligible for the program should be grandfathered so that existing services are not disrupted.

b. Streamlining USAC process. The Rural Healthcare Center recommends that the FCC adopt a simplified annual process recertification. This will reduce the burden of applying for this program and maximize participation by rural health organizations.

DETAILED COMMENTS TO THE FCC

1. Allow state definitions of rural to determine eligibility for FCC programs. National definitions of "rural" have never accurately captured the large volume of rural regions in California. Because of the large size of our counties (some of which are bigger than states) [1] and our challenging geographic features that impact travel time and commute patterns, federal definitions that characterize whole counties as either "urban" or "rural" do not accurately capture the complexity of California's geography. This is why in 1990, the Office of Rural Health Policy added the "Goldsmith Modification" to the definition of "non-metropolitan" county used to define rural by the Office of Management and Budget. While the Goldsmith Modification was not perfect for California, it more accurately recognized that there were a significant number of rural communities within the boundaries of so-called "urban" counties.

The Rural Urban Commuting Area (RUCA) system recently adopted by the Office of Rural Health Policy is particularly troubling for California's rural communities. Analysis prepared by the California Office of Statewide Health Planning and Development (OSHPD) and the California State Rural Health Association, demonstrates that 84 rural health clinics and rural hospitals would lose their rural designation and thus not be eligible for universal service funding.

RUCA's impact on the NSRHN Telemedicine Network would also be extremely harmful. Three of our rural health facilities would no longer be considered "rural" under RUCA, thus losing their access to universal service funding. This represents a loss of Universal Service support of over $30,000 annually to these providers. More importantly, this means that their patients would no longer have access to telemedicine medical in their communities.

The irony of this situation is that these organizations are just as rural today as they were last year! Developing a national rural definition by necessity means that criteria and standards

must be broad enough to try to address the variety of factors that impact a community's degree of rural. RUCA uses three factors: urbanization, population density, and daily commuting. The three rural communities in our network who are no longer defined rural under RUCA (Fall River Mills, Round Mountain, and Shingletown) have not gotten considerably larger nor has their population density changed. However, they are within commuting distance of a larger urban area and thus, are no longer considered rural under RUCA. The flaw in this analysis is that the health care organizations in these communities serve those individuals who are NOT commuting out of the area: students, seniors, local businesses, public employees, etc. In addition, these organizations serve all of the residents during non-commute hours. Finally, the commuting measure does not take into account geographic features such as mountain passes that impede travel during bad weather and impact commute patterns. Using a measure of how many individuals are leaving a community to determine its degree of "rural" does not adequately describe the services and resources that are needed to serve the resident population.

To address the shortcomings of national definitions of rural, the California Healthcare Workforce Policy Commission (CHWPC) developed a geographical framework of sub-county units called Medical Service Study Areas (MSSAs). MSSAs are used to define communities within the state as frontier, rural, or urban and to identify them as "underserved" with regards to the distribution of health care resources. MSSAs use census tracts as their building block, do not cross county lines, and are developed through a comprehensive community-input process. OSHPD just completed reviewing all of California's 541 MSSAs based on 2000 Census data.

From the start of this process in 1976, the federal government has shown an interest in this state-driven, sub-county process for identifying health care service areas and data collection. In 1992, when California entered into a Cooperative Agreement with the Health Resources and

---

[1] For example, the County of Shasta is larger than at two New England states combined – the County of San

Service Administration (HRSA), one of HRSA's first initiatives was to recognize MSSAs as "rational service areas" for the purpose of determining federal designations such as Health Professional Shortage Area, Medically Underserved Area, and Medically Underserved Population (HPSA/MUA/MUP). For the past 11 years, HRSA has invested over $2.5 million in developing California's capacity to develop and update MSSA data.

California's MSSA system works well for California, but we would not presume that it would work as well for other states. **That is why our recommendation to the FCC is allow organizations to demonstrate they are rural under state definitions of rural that have been recognized by a federal agency.** This would acknowledge that states understand the demographics of their region and are closer to the communities that are impacted by these types of definitions. Adding a requirement that a federal government agency recognizes state-defined geographic designations ensures a minimal degree of federal oversight.

2. Allow organizations to use any available federal rural definition. We recognize that not every state has a designation process as comprehensive as the one we use in California. Yet we still believe that a "one-size-fits-all" national definition has never served the country well.

In 1997, the Federal Office of Rural Health Policy published a technical issues paper entitled *What is "Rural" and How to Measure "Rurality" – A Focus on Health Care Delivery and Health Policy.* This paper, prepared by the North Carolina Rural Health Research and Policy Analysis Center, describes various definitions of "rural" that were available at the time and provides advice on how best to make use of these definitions. After describing the myriad of definitions for rural that exist to determine eligibility for local, state and federal government programs, the researchers concluded that perhaps it is best <u>not</u> to develop a "fixed and firm

---

Bernadino, the largest county in the U.S., is larger than at least 8 other states.

definition", but to acknowledge that the diversity of rural communities can best be captured by using a more situational approach, as described in the concluding paragraph of the report:

> When considering the question of "what is rural?" in a policy or research context, it may be wiser to retreat from a fixed and firm definition of rural since the subject is a complex social construct where definitions are constantly being proposed and debated. It may be better to think in terms of classification systems or typologies specific to your policy problem in order to avoid the more philosophical conflicts that may arise. This type of policy definition approach to rurality is necessary for the analyst or policy maker who has to choose a system that is fair and applicable. Even if the choice is made to try to understand the fundamental and generalizable differences among rural and between rural and urban places, there are too many combinations of density, total population, adjacency, economic characteristics, or social structure, to allow for a truly simplified system of classification that will resist controversy. [2]

There have always been numerous, and sometimes conflicting, definitions of rural within different branches of the federal government. The need to have multiple definitions of rural reflects the relative weight of the many variables that can be used to define rural. Even the list enumerated in the above referenced report does not acknowledge the impact of geographic barriers, such as mountains, large lakes, and rivers can have on the isolation of a community that may be technically near an urban area. Whatever definition is used by a branch of the federal government, however, has gone a rigorous analysis to ensure it is as accurate as possible, given the factors of rural important to that agency. For example, RUCA emphasizes community distance, while other definitions focus on population density or size of incorporated area.

State definitions of rural, because they can more accurately reflect the nuances of rural within their boundaries, really are the preferred method. But if the FCC is determined to use a federal definition, then it should acknowledge that even within the federal government, there is no agreement on "what is rural". **Therefore, rural health organizations should be able to**

---

[2] Ricketts, Thomas C and Johnson-Webb, Karen. *What is Rural and How to Measure Rurality" – A Focus on Health Care Delivery and Health Policy.* North Carolina Rural Health Research and Policy Analysis Center. A Technical Issues Paper prepared for the Federal Office of Rural Health Policy, Health Resources and Services Administration. February, 1997.

demonstrate they are "rural" using any of the definitions recognized by the federal government.

3. Develop an appeal process. We recommend that the FCC allow rural health organizations to use rural definitions developed by states or to use any one of the exiting federal definitions. However, if the FCC is determined to use only one definition to determine eligibility for the universal service program, it **should also establish an appeal process to enable rural communities who do not neatly fit into the national standard to demonstrate their eligibility.**

This appeal process should be simple and straightforward, and should be managed by the USAC staff to ensure that appeals are processed in a timely and responsive manner. Criteria that could be used to determine whether a community is indeed rural include:

a. Defined as rural under any other federal program
b. Defined as rural under a state-developed program that has been approved by a federal agency.
c. Other mitigating factors that demonstrate the community is indeed "rural".

We reiterate that we do not recommend that the FCC adhere to one single rural definition. However, if this is the intent of the Commission, then an appeal process would ensure that those organizations that are disenfranchised because of the arbitrary nature of a single rural definition have an opportunity to provide facts that will help demonstrate their eligibility for the universal service program.

4. Grandfather existing rural health organizations currently receiving universal service funds. While federal definitions of rural may change, the rural nature of the communities being served by this program do not change. Within our network, three organizations that currently meet the eligibility criteria of the program could be ineligible if the

FCC decides to use RUCA or a whole county based definition such as OMB. Yet these rural health organizations are still isolated from their nearest urban area, they still suffer from inadequate access to telecommunications services, and their patients still need the valuable services that telemedicine is providing them. **Thus, if the FCC changes the definition of rural in such a way that does not allow for organizations who are currently defined rural to participate in the program, then it should "grandfather" these organizations.** This would ensure that the patients served by these organizations continue to receive needed services, even though they no longer meet the arbitrary standards established by a unit of the federal government.

5. Develop simplified recertification process. As an individual who has worked with this program since 1999, one of the most cumbersome aspects of the process is the need to annually fill out the same paperwork when nothing substantial has changed. There have been no changes in the structure or location of the organization receiving the discount, the telephone lines are still intact and functioning, there are no alternatives to the service because frankly, there is still very little competition to serve smaller, more remote areas of the country. The only factor that is likely to change every year is that the cost of the services covered by USAC has increased!

Once an organization has demonstrated its eligibility for the program and it has started receiving discounts from USAC, **a significant amount of time, energy, money, and paper could be saved if USAC went to an annual, on-line "re-certification" process.** Once per year, USAC could e-mail a one-page form to all current USAC recipients that asks the organization to:

a. Certify that they still meet the eligibility criteria for the program
b. Identify any changes in the configuration or cost of the lines that are covered by the USAC program. If there are changes, then a supplemental form could be included to provide the necessary detail to enable USAC to process the changes.

c. If an organization no longer wishes to receive USAC support, this annual form could be used to "de-activate" an organization.

This annual recertification process does not relieve the organization of the responsibility of notifying USAC if significant changes have occurred during the year that may impact the amount of subsidy received. But most often, the cost changes during the year are minor enough that organizations can afford to wait to adjust their USAC request on an annual basis.

We recommend that USAC take the initiative to send out this annual recertification, because this will ensure that organizations review their universal service infrastructure to be sure it is current. If the form is simple, straightforward, and able to be completed on-line, this will relieve the burden of completing three forms every year for the same service.

CONCLUSION

The overarching policy goal of the Rural Health Care Universal Service program is to expand the benefits of advanced telecommunications to the nation's rural communities. This policy goal is not achieved if the Commission narrows the definition of rural to exclude communities who deserve to benefit from the program. Therefore, when approach the question of who is rural, we urge the FCC to use as liberal approach as possible – one that acknowledges the diversity and complexity of rural and serves to broaden, not limit, participation in the program.

In closing, we would like to acknowledge the incredible benefit that the Universal Service program has had on the quality of patient care in rural northeastern California. Without the support of this program, rural children would be unable to see psychiatrists, rural HIV/AIDS patients could not communicate with medical specialists, and rural doctors would be traveling hundreds of miles to receive medical education. This program works, it has been improved over the years, and we look forward to many more years of benefit from the program.